Holistic Medical Center

Pediatric Intake Form

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Patient Name: ____ **DOB:** ___________

Address: ____

City: ______________________________ **State:** ______________ **Zip:** ___________

Phone Home: ____________ **Cell:** ______________ **Sex: M F** **Grade of School:** _____

Mother's Name and Occupation: ____

Father's Name and Occupation: ____

Parents are (circle): Married Separated Divorced Living Together Other: ______________

Reasons for Office Visit: ____

____

____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Regular Pediatrician name and city located in:

____

Last time you had blood work done and with what physician:

____

List All Surgeries & Hospitalizations, including date occurred:

____

____

____

List All medicines (from drugstore or prescription) child is on now:

Name	Dose	For How Long

List all supplements child is taking:

Name	Dose	For How Long

Any known Allergies to food, drugs, environment, animals:

Previous Medical History

YES (Y) indicates the child gets the problem **regularly; NO (N)** indicates the child **never** had the problem; **PAST (P)** indicates the child had the problem in the **past, but not recently.**

Please circle the correct one for your child:
Ear Infections: Y N P **If has had, how many total**: ____________________

Colds: Y N P **If has had, how many total**:____________________

Strep Throat: Y N P **If has had, how many total**: ____________________

How many times has the child taken antibiotics: ____________________
What other medicines has the child taken and how often:

____

____

____

Hearing Tests Normal: Yes No Not Tested

Vision Tests Normal: Yes No Not Tested

Speech Impediments: Yes No Past

Learning Impediments: Yes No Past

Vaccination History:

YES, has had; **NO**, has not; **SOME**, did not finish all shots:

MMR: Yes No Some **DPT**: Yes No Some **Hep B:** Yes No Some

Hib: Yes No Some **Chicken Pox**: Yes No Some **Polio**: Yes No Some

Other: ____________________

Any reactions to vaccinations? If so, please explain:

____

____

Family History:

Allergies: Y N P **Obesity**: Y N P **Cancer**: Y N P

Tuberculosis: Y N P **Mental Illness**: Y N P **Cardiovascular Disease**: Y N P

Diabetes mellitus: Y N P

Mother's Pregnancy History:

Age at conception: _________
Did she have other children already? Yes No

Health During Pregnancy:

Smoking: Y N **Diabetes**: Y N **Coffee**: Y N
Nausea/Vomiting: Y N **Recreational Drugs**: Y N **Emotional Stress**: Y N
Preeclampsia: Y N **Length of Labor** :____________ **Vaginal Birth**: Y N
Traumatic Birth: Y N
If the birth was difficult, please explain: ____

Health of baby at birth:____

Health History of Child:

Child Breastfed: Y N **For how Long**:__________________ **When put on formula**:_______

What formula was used: _________________ **Age child started solid food:**____________

When did child walk:__________ **Talk**:_____________ **Develop Teeth:**____________
Jaundice as baby: Y N **Colic:** Y N
Cradle Cap: Y N **Anemia:** Y N
Eczema or Psoriasis: Y N **Asthma:** Y N
Diarrhea: Y N **Warts:** Y N
Constipation: Y N **Nightmares:** Y N
Finicky Eating: Y N **Bed-wetting:** Y N
Poor Teeth: Y N **Tantrums:** Y N
Chronic Sniffles: Y N **Disobedient:** Y N
Bad Foot Odor: Y N **Fears/Phobia:** Y N
Very Sweaty Baby/Child: Y N
Hyperactivity: Y N
Headaches: Y N **Stomach Aches:** Y N

Any Particular household or other life stressors child has witnessed or gone through:

____

____

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint?_____

If so, what sort of pollution were you exposed to?_______________________________________

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all?_________________________________

Does the child seem particularly sensitive to perfumes, gasoline or other vapors?_______

Do you spray pesticides, herbicides or other chemicals around your home?____________

Anything else you'd like to add:

____

____